

Draft date: 10/19/26

Virtual Meeting

HEALTH RISK-BASED CAPITAL (E) WORKING GROUP

Wednesday, October 28, 2026

12:00 – 1:00 p.m. ET / 11:00 a.m. – 12:00 p.m. CT / 10:00 – 11:00 a.m. MT / 9:00 – 10:00 a.m. PT

ROLL CALL

Steve Drutz, Chair	Washington	Tish Becker	Kansas
Danielle Smith, Vice Chair	Missouri	Michel Laverdiere	New York
Wanchin Chou	Connecticut	Diana L. Sherman	Pennsylvania
Kyle Collins	Florida	Bing Wu/Sean Fulton	Texas

NAIC Committee Support: Derek Noe/Maggie Chang

AGENDA

1. Consider Adoption of its July 15 Minutes—*Steve Drutz (WA)* Attachment 1
2. Discuss its Working Agenda—*Steve Drutz (WA)* Attachment 2
3. Receive a Referral from the Statutory Accounting Principles (E) Working Group Attachment 3
—*Steve Drutz (WA)*
4. Receive the Report of the Managed Care Credit Drafting Group
—*Steve Drutz (WA)*
5. Discuss the Forecasting Tool for H2 Report Factors—*Steve Drutz (WA)*
6. Discuss Any Other Matters Brought Before the Working Group
—*Steve Drutz (WA)*
7. Adjournment

Draft: 7/27/26

Health Risk-Based Capital (E) Working Group
Virtual Meeting
July 15, 2026

The Health Risk-Based Capital (E) Working Group of the Capital Adequacy (E) Task Force met July 15, 2026. The following Working Group members participated: Steve Drutz, Chair (WA); Danielle Smith, Vice Chair (MO); Wanchin Chou (CT); Carolyn Morgan (FL); Tish Becker (KS); and Bing Wu (TX). Also participating were: Cameron Piatt (OH) and Amy Malm (WI).

1. Adopted its May 7 Minutes

The Working Group met May 7. During the meeting, the Working Group took the following action: 1) adopted its Spring National Meeting minutes; 2) referred proposal 2026-03-CA to the Capital Adequacy (E) Task Force; 3) received comments on phase-in analysis; 4) discussed a Managed Care Credit Drafting Group; and 5) discussed data used in the American Academy of Actuaries (Academy) H-2 Underwriting Risk Report.

Smith made a motion, seconded by Chou, to adopt the Working Group's May 7 minutes (Attachment XX). The motion passed unanimously.

2. Discussed the 2025 Health RBC Statistics

Drutz said the 2025 health risk-based capital (RBC) statistics were run on June 1 (Attachment XX). There were 1,145 health RBC filings loaded into the NAIC database, up from 1,143 in 2024. There were 23 companies that triggered an action level in 2025. Of which, nine were in company action level; four were in regulatory action level; three were in authorized control level (ACL); and seven were in mandatory control level. There were 20 companies that triggered the trend test. The ACL RBC and total adjusted capital (TAC) increased from 2024 to 2025. Drutz asked NAIC committee support to describe the changes to the descriptions. Derek Noe (NAIC) said the aggregate premium line was updated to include Medicaid and Medicare premium, and the aggregate claims line was already including Medicaid and Medicare amounts. Drutz asked if there were objections to posting the statistics to the Working Group web page, and hearing none, instructed NAIC committee support to do so.

3. Adopted the 2026 Health RBC Newsletter

Drutz said the 2026 health RBC newsletter includes all proposals adopted by the Working Group for year-end 2026 to the health RBC forecasting and instruction publications. The adoption concerns the newsletter content, as the format will be formalized at a later time.

Chou made a motion, seconded by Becker, to adopt the 2026 health RBC newsletter (Attachment XX). The motion passed unanimously.

4. Received Comments on the Request for Additional Data Analysis Ideas

Drutz said the Working Group exposed the underwriting analysis of companies that filed the Health Blank during the May 7 meeting, with a 32-day comment period ending June 8. The Working Group received two comment letters, one from AHIP and one from UnitedHealth Group (UHG) (Attachment XX).

Ray Nelson (AHIP) said that AHIP appreciated the additional data, and the most recent underwriting years were unlikely to change the underlying factors. He asked if the analysis could be done by company size and the total change in RBC by company size. There was also interest in an analysis presented using the different time horizons from the Academy H-2 Underwriting Risk Report, and in the possibility that, once the Academy answers the questions the Working Group originally sent to them, AHIP may have additional follow-up questions.

Nelson said that the timeline for the phase-in of the factors remained important and suggested a five-year phase-in may be useful to allow the industry to adapt to the changing factors in terms of reinsurance and company impact. Drutz said the Managed Care Credit will not be completed in the near future, and the implementation of factors should not depend on the new Managed Care Credit. Implementing the increased factors would be difficult without the diversification credit beyond the first third of the increase. To facilitate this, Drutz asked NAIC committee support to draft a memo to the Academy to request assistance with the diversification credit. Drutz said the Working Group needs to decide on the length of the phase-in.

Drutz asked NAIC committee support if the data analysis proposed in the comment letter seemed reasonable. Noe said yes. Nelson said that taking the first step of a phase-in and then waiting to see the results in the industry was an option. Drutz said the Working Group would consider each step of the phase-in individually and not adopt all the changes at once, to allow the Working Group to analyze the impact of each change.

James Braue (UHG) said the underwriting loss information was interesting but would be difficult to draw conclusions without additional analysis. UHG suggested that the profit and loss be presented as a percentage of premium, since company size is strongly related to solvency. It also suggested to examine profit or loss relative to the company action level RBC, since it is available in the annual statement, and the underwriting component is a major factor in most companies' RBC. The data could also be presented using the risk levels from the Academy's analysis that developed the new underwriting factors, and future analyses could be presented in a similar fashion. Braue also suggested excluding companies that did not have business reported on page XR013 of the RBC report, and including any companies that had zero net underwriting and wrote business that appeared on XR013. Companies could also be stratified by size based on premium volume and suggested utilizing quintiles. Companies could also be stratified by the number of lines of business on XR013, providing a starting point for examining diversification.

Braue also asked whether the losses could be associated with specific lines of business to help prioritize future factor updates. Chou said that the key driver of the increase in underwriting loss is affordability, due to rising unit costs in the health industry, similar to the increase in material costs affecting the property/casualty (P/C) industry, and asked how the companies could help gather data for analysis. Braue said that the state rate filings had some information that could be examined but not in a public way, and he did not know if there was an effective way to gather the information from the companies directly. The estimate of cost trends also changes over time as more data is gathered, and any information collected about future costs would need to account for the data's maturity. Before data could be collected, there would need to be discussions about how to collect such data and the definitions of the data to be collected. Braue agreed that the current analysis would not get to the underlying causes, but hoped it would help identify the size of the problem and where it is occurring. The analysis suggested in the comment letter could help identify which factors to prioritize when implementing the RBC formula.

Chou said that he and the Working Group members would discuss the affordability issue and follow up with UHG. Drutz asked NAIC committee support whether the data could be presented by risk percentiles and if there were any concerns with the other requests. Noe said presenting risk percentiles would require the Academy's help and could not be developed in the near future. The presentation of the data in quintiles would not be that different from presenting data in quartiles, as mentioned in previous letters. Drutz asked whether UHG or AHIP had a preference for quintiles or quartiles, and whether quintiles might create too many subsets. Braue said the

suggestion for quintiles was so there would be more information in the small sections but saw little difference between quartiles and quintiles as the basis of division. Drutz said that he believed the quartiles would be easier to use and advised NAIC committee support to move forward with quartiles in future analysis.

5. Discussed Time Horizon in Factor Development

Drutz said the Working Group needs to decide on the time horizon to use for implementing the updated risk factors from the Academy report. The Academy provided one-year, three-year, and five-year time horizons, with the longer time horizons generally smoothing the data and reducing the factors. Drutz said health care tends to have short-tailed annual costs, and using longer durations would reduce the impact of annual claim fluctuations, which may not capture the risk associated with annual volatility. The RBC calculation is a moment-in-time calculation, and the one-year time horizon may make the most sense, but the Working Group will continue to discuss the topic, as a final decision will need to wait for the Academy's response to the questions sent by the Working Group. Drutz also reiterated that the phase-in approach would be implemented, with work on a diversification credit, and that the Working Group would continue discussing the appropriate safety level during future calls. Chou said that the safety level may be a bigger subject as the P/C RBC formula has a similar discussion, and the Working Group may need to collaborate with other NAIC Working Groups and the Academy on the topic. Drutz said the P/C RBC formula currently utilizes an 87.5% safety level and that health should be consistent unless the Working Group has a reason to differ.

6. Discussed State Directed Payments and Medicaid Pass-Through

Drutz said that the state-directed payments and separate payment terms under the new Medicaid rules are transitioning to an at-risk program, according to the Centers for Medicare & Medicaid Services (CMS) guidance. At-risk payments would be treated as premiums, not pass-through payments, for reporting on page XR013 of the RBC report.

Malm asked whether this would preclude companies from entering values in the Medicaid pass-through line on XR013, and whether these payments should have a different risk charge and represent the same level of risk as other Medicaid premiums. Drutz said that payments that fall under CMS rules would be excluded from the reporting line and that the data analysis to reduce the factor would take time.

Piatt asked for clarification on the payment names. Robin Marcotte (NAIC) noted that the CMS guidance refers to them as state-directed payments and state payment terms. Malm agreed that the data analysis would take time and noted that these payments may go by different names in different states. She asked if the instructions for page XR013 would be updated. Drutz said that the instructions would not be changed for 2026 reporting but could be changed in the future if the Working Group decided to pursue the topic further.

7. Discussed Other Matters

Drutz reminded the Working Group that the Risk-Based Capital Model Governance (EX) Task Force had asked it to provide feedback on any known inconsistencies or gaps in the health RBC formula. The Managed Care Credit Drafting Group will meet on Aug. 3 to determine the current types of managed care agreements and descriptions, and which new types are needed.

Having no further business, the Health Risk-Based Capital (E) Working Group adjourned.

Priority 1 – High Priority
 Priority 2 – Medium Priority
 Priority 3 – Low Priority

**CAPITAL ADEQUACY (E) TASK FORCE
 WORKING AGENDA ITEMS FOR CALENDAR YEAR 2027**

2026 #	Owner	2026 Priority	Expected Completion Date	Working Agenda Item	Source	Comments	Date Added to Agenda
Ongoing Items – Health RBC							
X1	Health RBC WG	Yearly	Yearly	Evaluate the yield of the 6-month U.S. Treasury Bond as of Jan. 1 each year to determine if further modification to the Comprehensive Medical, Medicare Supplement and Dental and Vision underwriting risk factors is required. Any adjustments will be rounded up to the nearest 0.5%.	HRBCWG	Adopted 202 ~~65~~ -03-CA (YE-202 ~~65~~)	11/4/2021
X2	Health RBC WG	3	Ongoing	Continue to monitor the Federal Health Care Law or any other development of federal level programs and actions (e.g., state reinsurance programs, association health plans, mandated benefits, and cross-border) for future changes that may have an impact on the Health RBC Formula.	4/13/2010 CATF Call	Adopted 2014-01H Adopted 2014-02H Adopted 2014-05H Adopted 2014-06H Adopted 2014-24H Adopted 2014-25H Adopted 2016-01-H Adopted 2017-09-CA Adopted 2017-10-H The Working Group will continually evaluate any changes to the health formula because of ongoing federal discussions and legislation. Discuss and monitor the development of federal level programs and the potential impact on the HRBC formula.	1/11/2018
Carryover Items Currently being Addressed – Health RBC							
X3	Health RBC WG	2	Year-End 202 ~~76~~ RBC or Later	Consider changes for stop-loss insurance or reinsurance.	AAA Report at Dec. 2006 Meeting	(Based on Academy report expected to be received at YE-2016) 2016-17-CA Adopted proposal 2023-01-CA	

X4	Health RBC WG	1	Year-End 2026 or later <u>(Completed)</u>	Change the Structure of page XR013, PR020, and LR020 to align with the lines of business found on Page 7 Analysis of Operations. Add separate line to separate the Investment Income Adjustment from the factors	HRBCWG	Separation of H-2 Underwriting Review <u>Adopted 2025-15-CA Mod 5/15/2026</u>	9/29/2025
X5	Health RBC WG	1	Year-End 202 ~~7~~ ⁶ or later	Expand Exhibit 7 to include new modes of Managed Care Business Expand to collect data by line of business found on Page 7 Analysis of Operations	HRBCWG	Separation of H-2 Underwriting Review <u>Created Managed Care Credit Drafting Group</u>	9/29/2025
X6	Health RBC WG	1	Year-End 2027 or later	Develop implementation of updated factors for pages XR013, PR020, and LR020	HRBCWG	Separation of H-2 Underwriting Review	9/29/2025
X7	Health RBC WG	3	Year-End 202 ~~7~~ ⁶ or later	Discuss and determine the re-evaluation of the bond factors for the 20 designations.	Referral from Investment RBC July/2020	Working Group will use two- and five-year time horizon factors in 2020 impact analysis. Proposal 2021-09-H - Adopted 5/25/21 by the WG	9/11/2020
X8	Health RBC WG	2	Year-End 202 ~~8~~ ⁷ or later	Discuss incorporating designations for non-bond debt on schedule BA resulting from the adoption of the principle based bond definition.	Referral from SAP WG	WG will review 202 ~~6~~ ⁵ filings to determine prevalence	4/30/2025
X9	Health RBC WG	2	Year-End 2028 or later	Analyze long-term care insurance (LTCI) underwriting performance to create a more nuanced set of risk factors that considers pricing changes over time.	HRBCWG	Academy Created LTCI group to work on this	4/30/2025
New Items – Health RBC							

MEMORANDUM

TO: Steve Drutz, Chair (WA), Health Risk-Based Capital (E) Working Group
Danielle Smith, Vice Chair (MO), Health Risk-Based Capital (E) Working Group
FROM: Kevin Clark, Chair (IA), Statutory Accounting Principles (E) Working Group
Dale Bruggeman, Vice Chair (OH), Statutory Accounting Principles (E) Working Group
DATE: August 31, 2026
RE: Notification of Exposure Agenda item 2026-13: Medicaid Updates

At the Summer National Meeting the Statutory Accounting Principles (E) Working Group exposed agenda item 2026-13: Medicaid Updates until Oct. 2 and directed the Health Risk-Based Capital (E) Working Group be notified of the exposure.

This agenda item is to address questions received from industry and regulators regarding statutory accounting for state directed payments (SDP) in Medicaid managed care and for separate payment terms. The primary question is regarding whether the statutory reporting guidance classifies such payments as “at risk” under *SSAP No. 54—Individual and Group Accident and Health Contracts*. Key points are described below:

State directed payments - are based on the utilization and delivery of services and are further detailed in in 42 Code of Federal Regulations (CFR) [§ 438.6\(c\)](#). These payments are also tied to quality goals.

Separate Payment Terms – are a mechanism used by states to send supplemental funding to providers through managed care organizations (MCO) for state directed payments that were separate from the per member per month payments. A 2024 final rule for Medicaid MCO contracts, prohibits the use of separate payment terms on or after July 9, 2027 per CMS-2439-F regulation. It requires that all state directed payments be included in actuarially sound capitation rates. It requires SDP separate payment terms (SPTs) must be moved into the base capitation rates paid to plans.

State directed payments are not pass throughs - 42 CFR 438.6(a) defines a pass-through payment as an amount required by the state to be added to contracted payment rates and considered in the actuarially sound capitation rate, that is not tied to a specific service or benefit, and not a permitted 438.6(c) payment methodology (i.e., SDP). CMS treats 438.6(c) SDPs as distinct from 438.6(d) pass-throughs: SDPs are service-specific and tied to utilization.

State directed payments are “at risk” - As provided for in the 2024 Medicaid and CHIP Managed Care Final Rule, CMS amended 438.8 (Medicaid MLRs) to clarify that SDPs and SDP SPTs are to be included in both the medical loss ratio (MLR) numerator and denominator. The inclusion of SDPs and SDP SPTs in both the MLR numerator and denominator indicates that CMS views these dollars as “at risk” to the MCO despite being embedded in the capitation rate with state direction on where the money flows.

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Despite the classification of being “at risk” some MCOs view some state directed payments and state directed payments from separate payment terms as low-to near-zero-risk because the state directs the payment to specified providers, and historically some MCOs exclude state directed payments from MLR reporting on a pass-through analogy.

Because the HRBC formula removes pass through payments from the underwriting risk charges and assigns a lower charge that is more akin to an administrative services contract to pass through payments. The SAPWG staff also received questions regarding whether the amounts should receive a risk charge similar to pass through payments in health risk-based capital (RBC) reporting, but the SAWPG defers to the Health Risk-based Capital (E) Working Group for this topic. The current health RBC (HRBC) guidance for XR-013 underwriting risk and XR-015 other underwriting risk appears to defer to the Medicaid classification of pass-throughs.

The SAPWG exposed revisions to *SSAP No. 47—Uninsured Plans* and *SAP No. 54—Individual and Group Accident and Health Contracts* to add a principles-based statement that Medicaid contracts payments classified as capitated payments are included in insured plans. This should cover the Medicaid revisions regarding state directed payment and separate payment terms without having to become too detailed regarding program terminology.

Comments, if any, are requested by Oct. 2. Comments should be addressed to Kevin Clark, chair of the Statutory Accounting Principles (E) Working Group, and submitted to NAIC staff of the Working Group. As discussed above, the Working Group defers to Health Risk-Based Capital (E) Working Group regarding determination of risk charges.

Cc: Robin Marcotte rmarcotte@naic.org; Jake Stultz jstultz@naic.org; Julie Gann jgann@naic.org; Jason Farr jfarr@naic.org; Wil Oden woden@naic.org; Maggie Chang mchang@naic.org; Derek Noe dnoe@naic.org